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No. 97-303

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

Humana Inc. and
Humana Health Insurance of Nevada, Inc.,

Petitioners,

v.

Mary Forsyth, Marietta Cade,
Willie Andrews, Mary Lou Buehler,
Helen Staves, Randolph Bratton,
and Searle Auto Glass, Inc.,

Respondents.

On Writ of *Certiorari* to the United States Court of Appeals for the Ninth Circuit

BRIEF OF *AMICUS CURIAE* TRIAL LAWYERS FOR PUBLIC JUSTICE, P.C., IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICUS CURIAE*[1]

Trial Lawyers for Public Justice ("TLPJ") is a national public interest law firm that is dedicated to pursuing justice for the victims of corporate and governmental abuses. Litigating throughout the federal and state courts, TLPJ prosecutes cases designed to advance consumers' and victims' rights, environmental protection and safety, civil rights and civil liberties, occupational health and employees' rights, the preservation and improvement of the civil justice system, and the protection of the poor and the powerless. Through its involvement in precedent-setting and socially-significant litigation, TLPJ seeks to ensure that the civil justice system fully serves its dual purposes – compensating those injured by wrongful conduct and deterring similar conduct in the future. TLPJ is gravely concerned that, if insurance companies are shielded from liability under RICO, these two purposes will be severely undermined.

In this case, the Court must decide whether a health insurer alleged to have committed a pattern of massive fraud against its policyholders should be held liable only for the contractual damages provided for by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132, or should be held liable for treble damages if Respondents prove their RICO claims to a jury. The Court's decision will have broad implications for every American, as virtually no American's life is untouched by the insurance industry. The outcome of this case will determine whether citizens will be foreclosed from using the most effective remedy against organized fraud and abuse against the insurance industry.

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[1]Letters of consent to the filing of this brief have been filed with the Clerk. No counsel for any party authored the brief in whole or in part, and no person or entity other than *amicus curiae* made any monetary contribution to its preparation or submission.

STATEMENT

The sole issue in this case is whether insurance companies are exempt from private civil suits under the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. § 1964(c) (Supp. I 1995), by virtue of the McCarran-Ferguson Act's limitation on Federal regulation of the insurance industry. 15 U.S.C. § 1012(b). The United States Court of Appeals for the Ninth Circuit held that such suits are not barred because they do not conflict with State regulation of the insurance industry, and thus do not "invalidate, impair, or supersede" State insurance laws within the meaning of the McCarran-Ferguson Act. 15 U.S.C. § 1012(b).

Respondents maintain that Petitioner Humana, along with a hospital participating in its preferred provider organization, engaged in an elaborate kickback scheme to defraud its policyholders. Respondents are policyholders under an insurance contract with Humana, under which Humana was contractually obligated to pay 80% of policyholders' hospital stays, and policyholders were obligated for a 20% co-payment. J.A. 117. Respondents allege that Humana secretly obtained discounts from a hospital participating in Humana's preferred-provider organization. *Id.* Instead of passing those discounts on to its policyholders in the form of a reduced co-payment, Humana fraudulently concealed the discounts from Respondents. J.A. 126. The result, Respondents contend, is that in some instances the discount was so large that the total hospital bill was less than the co-payment Respondents were forced to pay on the undiscounted rate. *Forsyth v. Humana, Inc.*, 827 F. Supp. 1498, 1508 (D. Nev. 1993). In other words, Humana more than covered its own costs with the policyholder's co-payment. Respondents further allege that Humana engaged in elaborate deception to conceal the discounts from its insureds and misrepresent the co-pay arrangement through direct mail, television and radio advertisements, and telemarketer solicitations. *Id.* at 1516.

Under ERISA, which does not allow recovery of extra-contractual damages, the district court ordered Humana to

reimburse its policyholders the excess co-payment, *i.e.*, the amount policyholders paid Humana in excess of 20% of the discounted rate. 827 F. Supp. at 1508. The district court also held, however, that Respondents' State law claims, including their State RICO claim, were preempted by ERISA, and that Respondents' Federal RICO claims were barred by the McCarran-Ferguson Act. *Id.* at 1509, 1520. On appeal, the Ninth Circuit affirmed the award of ERISA relief, but reversed the district court's ruling dismissing the Federal RICO claims. *Forsyth v. Humana, Inc.*, 114 F.3d 1467, 1475, 1480 (9th Cir. 1997). Humana then sought review by this Court, which was granted.

SUMMARY OF ARGUMENT

The result reached by the district court, and urged by Petitioners here, demonstrates why preclusion of civil RICO suits by McCarran-Ferguson enables perpetuation of fraud in the insurance industry. The district court dismissed Respondents' State law claims as preempted by ERISA. However, the ERISA remedy awarded by the district court merely placed Humana in the financial position it would have been in had it not concealed the discounts. RICO, in contrast, was designed to impose more powerful and effective remedies, to undermine the economic power the racketeer derives from its fraud, and to prevent it from repeating its wrongful conduct in the future. The court of appeals' decision reinstating Respondents' RICO claim therefore unleashes a powerful tool for combating insurance fraud.

The lower court's decision, moreover, is entirely consistent with the Congressional purposes underlying RICO. RICO was enacted for the express purpose of eradicating systematic fraud and abuse in every sector of the economy, including the insurance industry. In enacting RICO, Congress recognized that State regulators and law enforcement agencies had insufficient means to combat what had become an increasingly widespread and devastating problem for consumers. Mindful of the States' authority to investigate and prosecute criminally and civilly fraudulent activity within their own borders, Congress specifically

designed RICO to supplement those efforts by providing for criminal and civil prosecution of racketeering activity in interstate and foreign commerce. To ensure the effectiveness of the law, Congress enacted powerful criminal and civil penalties, which include treble damages for businesses or consumers who suffer economic losses as a result of violations of RICO. These penalties create an effective means for private citizens to fight the sort of interstate insurance fraud that State regulators are powerless to address.

Recent Congressional investigations confirm the vital role that RICO can and should play in combating insurance fraud. Such investigations have revealed that gaps in the reach and effectiveness of State insurance regulation has created a climate ripe for interstate and international insurance fraud. Recent years have witnessed several significant instances of interstate and international racketeering activity that have cheated consumers out of their premium payments and their insurance coverage. A handful of reported cases, including this one, bring to light other fraudulent schemes perpetrated by insurance companies, many of which present colorable civil RICO claims. These frauds, occurring in the health, life, property, and casualty insurance industries, cause severe economic impact, costing consumers tens of millions of dollars. As Congress predicted, State regulation alone has been inadequate to redress this wrongdoing.

RICO, on the other hand, is tailor-made for rooting out this type of fraud. In cases of health insurance fraud, such as this case, state law claims against health insurance plans covered by ERISA are preempted. Remedies under ERISA are limited to contractual damages, with no compensatory, consequential, or punitive damages. Even when state law claims are available and not preempted by ERISA, they lack RICO's powerful remedies, and are not as effective in eradicating fraud. Thus, in light of the relative weakness of State and ERISA remedies and the inability of State regulation to reach interstate and international fraud, it is critical that RICO be available to consumers to combat systematic fraud in the insurance industry.

ARGUMENT

II. THE McCARRAN-FERGUSON ACT DOES NOT PRECLUDE CIVIL RICO CLAIMS AGAINST INSURANCE COMPANIES BECAUSE RICO DOES NOT "INVALIDATE, IMPAIR, OR SUPERSEDE" STATE INSURANCE LAWS.

A. RICO's Plain Language Makes Clear That It Does Not Supersede State Law, But Rather Supplements It.

The McCarran-Ferguson Act provides that "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . ." 15 U.S.C. § 1012(b). The starting point for determining whether RICO "invalidates, impairs, or supersedes" State insurance regulations is not the McCarran-Ferguson Act, but RICO itself, which states that:

> Nothing in this title shall supersede any provision of Federal, State, or other law imposing criminal penalties or affording civil remedies in addition to those provided for in this title.

84 Stat. 947 (1970). Because RICO explicitly does not "supersede" State law, an entity sued in a private civil RICO suit may also be prosecuted criminally or civilly by State authorities, such as insurance regulators. RICO therefore does not violate McCarran-Ferguson's proscription on Federal interference in the regulation of the business of insurance.

Further evidence of Congress' intent that RICO supplement, but not supersede, State law is found in its definition of "racketeering activity," which includes "any act . . . which is chargeable under

State law . . ." 18 U.S.C. § 1961(1).[2] Because the statute expressly provides that a racketeer can be prosecuted under both State law and RICO, this Court has interpreted RICO as not in any way "superseding" State law. *See United States v. Turkette*, 452 U.S. 576, 586-87 (1981) ("That Congress included within the definition of racketeering activities a number of state crimes strongly indicates that RICO criminalized conduct that was also criminal under state law, at least when the requisite elements of a RICO offense are present.") *See also Haroco, Inc. v. American Nat'l Bank & Trust Co. of Chicago*, 747 F.2d 384, 392 (7th Cir. 1984), *aff'd*, 473 U.S. 606 (1985) (RICO "supplements," rather than "supplants" state law).

As *Turkette* makes clear, Congress explicitly intended that Federal prosecutions under RICO and States' prosecutions under their own laws take place simultaneously, in order to buttress law enforcement efforts against wrongdoers who were not sufficiently deterred by States' law enforcement alone. Because RICO's civil enforcement provision incorporates the criminal definition of "racketeering," it is logical that *Turkette's* reasoning applies in the civil arena as well.[3] There can therefore be no claim that RICO

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[2] RICO makes it unlawful:

> for any person who has received any income derived, directly or indirectly, from a pattern of racketeering activity . . . in which such person has participated as a principal . . . to use or invest, directly or indirectly, any part of such income, or the proceeds of such income, in acquisition of any interest in, or the establishment or operation of, any enterprise which is engaged in, or the activities of which affect, interstate or foreign commerce. 18 U.S.C. § 1962(a).

[3] RICO's civil enforcement provision, 18 U.S.C. § 1964(c), also provides for civil enforcement by the Federal government or by private citizens:

> [a]ny person injured in his business or property by reason of a violation of section 1962 of this chapter may sue therefor in any appropriate United States district court and shall recover threefold the damages he sustains and the cost of the suit, including a reasonable attorney's fee.

supersedes State law, even in the civil context; rather, RICO plainly supplements State law. Private civil RICO actions against insurance companies thus do not fall within the McCarran-Ferguson Act's proscription of federal law that "invalidates, impairs, or supersedes" State insurance regulation.

B. Congress Intended That RICO Be Used to Eradicate Organized Fraud in All Sectors of the Economy, Including the Insurance Industry.

RICO's legislative history further reveals that Congress included powerful remedies, including the treble damages provision, because fraud by organized crime had made an "alarming expansion into the field of legitimate business," posing a "major threat to our institutions." 116 Cong. Rec. 607 (Jan. 21, 1970) (remarks of Sen. Byrd). "The vast economic power concentrated in this giant criminal conglomerate constitutes a dire threat to the proper functioning of our economic system." 116 Cong. Rec. 602 (Jan. 21, 1970) (remarks of Sen. Hruska). Congress therefore designed RICO to include the powerful civil enforcement mechanisms "which have been highly effective in removing and preventing harmful behavior in the field of trade and commerce" by undermining the economic power of racketeers. *Id* (remarks of Sen. Hruska). Without these potent civil remedies, modeled on the Federal antitrust laws, "[t]he consumer public will suffer from inflated prices, shoddy goods, and outright frauds." 115 Cong. Rec. 6993 (Mar. 20, 1969) (remarks of Sen. Hruska).

Moreover, Congress fully recognized that, in order for RICO to be effective in eradicating the infiltration of illegal enterprises into legitimate businesses, it must eliminate the economic means for the enterprises to continue their illegal operations in *all* sectors of the economy. SEN. REP. NO. 91-617, at 80-83 (1969). Congress found that fraud by organized syndicates had infiltrated nearly every industry, and that the insurance industry was not "immune from its grasping claws." *Id.* at 76; 115 Cong. Rec. 5874 (Mar. 11, 1969) (remarks of Sen. McClellan). Senator

McClellan, one of RICO's chief sponsors, noted that in addition to its infiltration into the insurance industry in general, fraud by organized syndicates had also infiltrated labor unions, and these syndicates had profited by manipulating insurance contracts. *Id.* Thus, Congress fully intended that RICO's enforcement mechanisms be applicable to patterns of racketeering in the insurance industry.

II. RICO IS A VITAL TOOL IN COMBATING INSURANCE FRAUD.

Recent Congressional investigations into insurance fraud have confirmed what Congress suspected when it enacted RICO in 1970: that States, acting alone, are powerless to combat interstate and international insurance fraud. In the late 1980s and early 1990s, two Congressional subcommittees conducted extensive hearings on insurance fraud. *See* STAFF OF SUBCOMM. ON OVERSIGHT AND INVESTIGATIONS OF THE HOUSE COMM. ON ENERGY AND COMMERCE, 103D CONG., 2D SESS., *WISHFUL THINKING, A WORLD VIEW OF INSURANCE SOLVENCY REGULATION* 1 (Comm. Print 1994) ("*WISHFUL THINKING*").[4] These subcommittees both found that State insurance regulators lack the resources to prevent and prosecute systematic fraud and corruption in the insurance industry. These investigations underscore the need for more powerful remedies – like RICO – to effectively prevent and deter this type of fraud.

[4] *WISHFUL THINKING* referenced hearings held by Subcommittee in the 1980s and culminating in STAFF OF SUBCOMM. ON OVERSIGHT AND INVESTIGATIONS OF THE HOUSE COMM. ON ENERGY AND COMMERCE, 101ST CONG., 1ST SESS., *FAILED PROMISES* (COMM. PRINT 1990) and nine hearings held subsequently and culminating in *WISHFUL THINKING*; *see also Hearings Before the Permanent Subcommittee on Investigations of the Committee on Governmental Affairs of the United States Senate on U.S. Government Efforts to Combat Fraud and Abuse in the Insurance Industry,* 102d Cong., 1st. Sess. (1991).

A. Gaps in State Insurance Regulation Provide Opportunities for Insurance Scams.

The environment for organized insurance fraud is ripe in part because State regulators are not equipped to control the interstate and international nature of insurance fraud. McCarran-Ferguson's mandate that the States regulate insurance without interference by federal authorities has created gaps in regulation and enforcement of insurance companies, because State regulators can only control activities within their own state's borders. *See WISHFUL THINKING*, at 3. These gaps enable fraudulent insurance companies and their principals to set up shop in one State and then commit interstate fraud on a massive scale. SEN. REP. NO. 102-310, at 6-7 (1992). As a result, State laws and civil enforcement mechanisms are limited in their ability to prosecute organized insurance fraud. RICO helps fill the enforcement gap.[4]

Perpetrators of systematic insurance fraud circumvent or manipulate State regulatory processes, sell insurance illegally, steal consumers' premium payments, and leave their claims unpaid. These frauds occur in all facets of the insurance industry – property, casualty, health and life insurance.[5] *WISHFUL THINKING,* at 51. After the Senate and House subcommittees held

[4] Moreover, many states, including Nevada, where this case arose, permit only administrative proceedings by the insurance commissioner, but not private enforcement actions for violations of the State's unfair insurance practices. Nev. Rev. Stat. § 686A.160. In Nevada, the insurance commissioner also may bring judicial proceedings to prosecute fraudulent acts not specifically defined by the Code. A court may issue cease and desist orders and the commissioner may assess penalties, but no private right of action exists. Nev. Rev. Stat. § 686A.170. Thus, Respondents here had no cause of action under the State insurance code. Because their other State claims were barred by ERISA, they were left with only ERISA's contractual remedy.

[5] The United States is the largest single market for insurance in the world. American consumers purchase about 35 % of the insurance sold in the world, making $482 billion in premium payments annually. *WISHFUL THINKING,* at 51. More than 5,000 insurance companies and operations collectively control almost $2 trillion in assets worldwide. SEN. REP. NO. 102-310, at 1.

their investigations and hearings, they concluded that the current system, which relies on State insurance commissions to regulate, enforce, and penalize insurance companies, lacks sufficiently stringent regulation and sufficiently effective enforcement. *Id.* at 11. *See also* SEN. REP. NO. 102-310. These legislators concluded that their investigation of fraud in the industry had "exposed the top of a number of international white-collar criminal syndicates" and that individuals involved in insurance scams "were equally willing and able to commit other fraudulent activities involving advance fee schemes, stolen or counterfeit securities, tax evasion, and money laundering." SEN. REP. NO. 102-310, at 27, 29. The perpetrators of these scams were able to defraud consumers by capitalizing on weaknesses in the States' regulatory and enforcement schemes.

1. Artful Operators Find Loopholes in State Regulations.

Fraudulent insurance companies and brokers evade detection and prosecution by exploiting loopholes in the States' regulatory schemes. For over a century, State regulation of insurance has been directed at certifying that insurance companies would not be rendered insolvent by claims made by their policyholders. SEN. REP. NO. 102-310, at 6. Each State and the District of Columbia requires an insurance company to obtain a license in order to conduct business in that State. *Id.* In order to obtain a license, the insurance company must prove that it has sufficient assets and surplus capital to pay out claims made against it. *Id.* Yet fraudulent insurance companies and their principals can and do easily evade these requirements, by deceiving State insurance regulators about their assets or by finding loopholes in the law which permit them to sell insurance without a license. *Id.* at 7-8. No matter what form the deception or evasion takes, the net result is the same: consumers pay billions of dollars in premiums each year, and many of them find that their premium payments vanished into the pockets of individuals who ran fraudulent companies that later became insolvent, leaving millions of dollars of unpaid claims. *Id.* at 2.

One of the most notorious exploiters of State regulatory loopholes was Victoria Insurance Company, which, in 1987, with the help of one of its principals – who also was a former Insurance Commissioner for the State of Georgia – obtained a license to sell insurance in Georgia. Victoria obtained this license by briefly holding the requisite $1.2 million in assets, and then transferring them offshore after receiving the license. In reality, then, Victoria was insolvent from the moment it was licensed by the State of Georgia. SEN. REP. NO. 102-310, at 10.

Eighteen months later, Victoria was in receivership. In that eighteen months, Victoria managed to conduct business in all 50 States, selling a variety of insurance products, and collecting $16 million in premiums. SEN. REP. NO. 102-310, at 2. When it went into receivership, Victoria had under $700,000 in assets and over $20 million in unpaid claims. *Id.*

Victoria was able to conduct business in the 49 other States without a license by working with "risk purchasing groups" and "surplus line brokers." Risk purchasing groups are groups of individuals or businesses for which insurance is unavailable in their State. Such risk pooling is authorized by the Liability Risk Retention Act of 1986, 15 U.S.C. §§ 3901 *et seq.* Risk purchasing groups can purchase insurance from an insurer not licensed in the purchasing group's members' State. SEN. REP. NO. 102-310, at 9. As a result, an insurance company selling to a risk retention group could be licensed, for example, only in Florida, but sell insurance to residents of Wisconsin and be free from oversight by Wisconsin insurance regulators.

Similarly, surplus line carriers sell insurance to people or businesses with risks that cannot be insured by the person's or business' resident State-licensed carriers. However, States vary in their requirements for permitting out-of-State insurers to sell surplus lines insurance. Some have "white lists," identifying "acceptable" surplus line brokers, and some have "black lists," identifying "unacceptable" brokers. Other States permit surplus line brokers to sell insurance if they meet certain reporting

requirements, but do not require them to meet any solvency requirements. SEN. REP. NO. 102-310, at 8-9.

Through these and other mechanisms, Victoria evaded scrutiny by State regulators outside of Georgia. Victoria's activities demonstrate how a fraudulent insurance company can dupe one State regulator, or possibly choose a lenient State in which to apply for a license, and then use risk purchasing groups and surplus line brokers to transact business in other States where regulation of insurance companies might be more stringent. This type of activity led one Congressional investigatory committee to conclude that "current State supervision in the U.S. is lacking in the key areas needed to achieve national solvency regulation. The major reasons are limited legal authority, inadequate resources, and poor coordination." *WISHFUL THINKING,* at 11.

2. Regulators Lack the Resources to Fully Assess Insurance Companies' Solvency.

Insurance fraud is also made possible because insurance regulators lack the resources to investigate and determine whether the assets listed on insurance companies' financial statements genuinely exist. SEN. REP. NO. 102-310, at 25. Because of these insufficient enforcement resources, some fraudulent insurance companies have been able to obtain State licenses by listing "assets" on their financial Statements that did not actually exist. This places consumers at risk that their insurance claims will not be paid.

One example of this practice involved an insurance company that listed as an asset an assignment interest in Government National Mortgage Association (GNMA) securities, claiming that the securities were assigned to the company by their owner. "[G]iven the respectability, security and legitimacy surrounding U.S. government securities, the GNMA bonds were extremely marketable and minimally scrutinized by regulators." SEN. REP. NO. 102-310, at 24. As it turned out, however, the insurers "were apparently using the [identifying] numbers of legitimate, actual

GNMA bonds without the knowledge or consent of the true owners." *Id.* at 25. In the most egregious case, two different insurance companies claimed to be leasing the same pool of GNMA securities at the same time. *Id.*

These companies were able to obtain licenses to sell insurance because "[s]ome State insurance departments appear to be overburdened and without the resources to investigate the authenticity of each asset claimed by each insurance company within its jurisdiction." SEN. REP. NO. 102-310, at 25. As a result, State insurance commissioners have called for increased assistance in combating organized insurance fraud. *See id.* at 23 ("[a]ll of the State insurance regulators at the July 19 [1991] hearing called for some type of additional federal assistance above and beyond making insurance fraud a federal offense.") One of these State regulators "saw the federal role in insurance regulation as filling the gaps in current State regulation, not in duplicating what the States already do."' *Id.* Allowing prosecution of private civil RICO actions satisfies those calls for stepped-up enforcement.

3. Offshore Insurance and Reinsurance Companies Are Unregulated in the United States Yet Do Business Here By Evading State Regulators.

Americans also lose millions of dollars each year to fraudulent offshore insurance and reinsurance companies and brokers. Offshore insurance and reinsurance companies, which are not regulated at all in the United States, comprise 40% of the commercial insurance market in the United States. *WISHFUL THINKING,* at 5. In 1992, American consumers paid more than $8.4 billion to foreign reinsurers, and also purchased substantial insurance coverage from offshore insurance companies. *Id.* at 51. While these companies are headquartered in various countries in Asia, the Caribbean, or Europe, they maintain offices in the United States, where they sell their products free from oversight by State regulators. In California alone, regulators predicted that

in 1992 consumers would pay $300 million in premiums to offshore reinsurers, and that Californians would incur $100 million in losses because of fraud by these companies. *Id.* at 23.

Offshore reinsurance companies frequently are "largely unregulated" in their countries and operate under "totally secretive conditions." SEN. REP. NO. 102-310, at 3. American regulators have no control over the solvency requirements for reinsurance and insurance companies domiciled overseas, yet these offshore insurers are permitted to sell reinsurance to licensed insurers in the United States. A foreign-owned subsidiary in the United States is subject to State regulation, but the foreign-domiciled parent, which controls the assets of the company and makes ultimate decisions as to whether claims are paid, are not. *WISHFUL THINKING,* at 51-53. Moreover, most policyholders, who are not parties to reinsurance agreements, are unaware that their insurer has purchased reinsurance. SEN. REP. NO. 102-310, at 5. The reinsurer therefore has no legal obligation to the policyholder, but when a claim must be paid, the solvency of the reinsurer determines whether the claim will be paid by the insurer. *Id.*

Operating along with brokers in this country, fraudulent offshore insurers and reinsurers have engaged in massive racketeering fraud against American consumers. The most prominent example of such an enterprise was a scam perpetrated against World Life and Health Insurance Company of Pennsylvania. Alan Teale, who also operated Victoria Insurance, again set up shop in Georgia acting as a broker for offshore reinsurance sold to World Life and Health. SEN. REP. NO. 102-310, at 14. Teale's network of Georgia brokers and intermediaries were exempt from Georgia insurance regulations because they were not in the business of insurance as defined by the Georgia regulations. This loophole in Georgia is also true for other States. *Id.* at 16-17.

Operating without regulatory oversight in the United States, Teale acted as a broker for reinsurance companies that also were unregulated in the United States. SEN. REP. NO. 102-310, at 16. Teale and his operators sold millions of dollars of phony reinsurance to World Life and Health, ultimately causing its financial collapse when it could not pay out claims, and leaving consumers without the insurance for which they had paid. *Id.* at 15-17.[6]

Teale's empire operated along with four offshore reinsurance companies with offices in the United States. Although their financial statements indicated otherwise, were seriously underfunded. SEN. REP. NO. 102-310, at 20. They listed phony assets, mostly in the form of worthless or overvalued securities, as proof of their financial solvency. *Id.* Some of these paper assets included bogus bonds purportedly issued by an Indian tribe, the identity of which could not be verified by regulators. *Id.* at 19. It was not until the Senate Subcommittee investigated the collapse of World Life and Health that it was discovered that the "tribe" was "a sham, run by a group of 'white' or 'Anglo' Americans for the sole purpose of financial self-enrichment." *Id.*

That Alan Teale surfaced repeatedly as a subject of Congressional investigators demonstrates how massive and widespread fraud can be orchestrated by a single operator. His ability to orchestrate these widespread and devastating fraudulent schemes underscores the weaknesses in the ability of State regulatory systems to combat this type of fraud.

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[6]Many of the individuals involved in this scam were criminally prosecuted under RICO. DEP'T. LAB. OFF. INSP. GEN. SEMIANN. REP., Apr. - Sept. 30, 1996, at 40-41.

4. Fraud in MEWAs (Multiple Employer Welfare Arrangements) Leaves Thousands of Consumers without Needed Health Insurance Coverage and Bilks Small Businesses of Premium Payments.

Small businesses and their employees are particularly vulnerable to insurance fraud committed by illegitimate multiple employer welfare arrangements ("MEWAs"). MEWAs, which often operate legitimately, provide affordable health insurance coverage to the employees of small businesses and non-profit organizations by pooling the employees of several employers into one group. Because traditional insurance has become virtually unaffordable for many small employers, they are extremely vulnerable to fraudulent MEWA operators offering low-cost insurance for their employees. Some of these employers and their employees have participated in MEWAs only to find that millions of dollars of their premiums have gone to support the lavish lifestyle of the MEWA principals who embezzle premium payments and then leave millions of dollars in unpaid claims after the MEWA or its underwriter becomes insolvent. The victims of this fraud and abuse typically are people of modest incomes who acquire the insurance through their employers because they otherwise could not afford their own insurance. *See* SEN. REP. NO. 102-262, at 6-7 (1992).

The opportunities for fraudulent MEWA operators are created in large part by a regulatory gap in the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*[7] While ERISA precludes most State regulation of the business ERISA plans, it "saves" State regulation of the business insurance, as that phrase is defined in the McCarran-Ferguson Act. 29 U.S.C. § 1144(b)(2)(A). Thus, to the extent a MEWA is

[7]In addition to the regulatory gap creating an environment ripe for fraud, ERISA's broad preemption provision creates a civil enforcement gap as well. *See* II.B., *infra*.

underwritten by an insurance company, the insurance company is subject to State licensing and solvency requirements. 29 U.S.C. § 1144(b)(6)(A). Such an insurance company, like any other insurance company, must, in order to operate in a State, obtain a license from the State insurance commission. The State regulators review its assets to determine that it is financially able to pay out claims. On the other hand, a "self-funded" MEWA, *i.e.*, one that is underwritten solely by the premium payments by the participating employers or unions, rather than by an insurance company, is exempted from regulation by the States. 29 U.S.C. § 1144(b)(6)(B).[8] Because ERISA contains no licensing or solvency requirements, no regulatory agency on the State or Federal level reviews the financial vitality of non-insurance-company MEWA sponsors to ensure that they own the assets necessary to pay claims. *Hearing Before the Subcommittee on Employer-Employee Relations of the Committee on Education and the Workforce of the House of Representatives*, 105th Cong. 2d. Sess. 14 (1997) (testimony of Kathleen Sebelius, Commissioner of Insurance, State of Kansas). Thus, a "self-insured" MEWA can avoid the principal purpose of insurance regulation – ensuring availability of assets to pay consumers' claims – by asserting that no insurance company is involved in underwriting its activities. SEN. REP. NO. 102-262, at 8.

Seizing on this hole in the regulatory scheme, some fraudulent MEWA operators – even if they were not sponsored by an employer or union – sought to avoid State licensing and solvency requirements by arguing that, because they were self-insured, they were covered only by ERISA. "ERISA has thus become a tactical legal weapon, freely used by many fraudulent MEWAs against the threat of State regulation." SEN. REP. NO. 102-262, at 9. By avoiding State solvency requirements, the typical fraudulent MEWA will engage in a "classic Ponzi scheme in which today's

[8]As originally enacted, ERISA was unclear as to whether State insurance commissions would regulate insurance companies underwriting MEWAs. In 1983, Congress amended the statute to clarify the States' jurisdiction over these insurance companies. 29 U.S.C. § 1144(b)(6).

benefit claims are paid out of tomorrow's premium monies." *Id.* at 6.

In one case of MEWA fraud, the operator of the MEWA, shielding himself from State insurance regulation by claiming the MEWA was governed solely by ERISA, falsely assured his customers that he was fully insured by Lloyd's of London and other reputable insurers, even though no such insurance exists. The MEWA operator, from his location in California, obtained approximately $5.8 million in premiums from consumers nationwide, but used the proceeds for his own personal use. Ultimately, the MEWA became insolvent, and the participants were left with over $3.7 million in unpaid medical claims. The operator was later convicted of wire fraud and money laundering. DEP'T. LAB. INSP. GEN. SEMIANN. REP. OCT. 1, 1996 - MAR. 31, 1997, at 45-46.

As a result of these evasive tactics by fraudulent MEWAs, many States began to recognize the need to regulate MEWAs that were not in fact sponsored by employers or unions and were not underwritten by insurance companies. However, as a result of this stepped-up State regulation, a new type of MEWA emerged, demonstrating the ability of fraud perpetrators to adapt themselves to new regulatory climates and evade the scrutiny of regulators. This new type of MEWA is a "bogus union" MEWA, sponsored by a "union" whose sole purpose is to operate the MEWA, and not to provide representation to workers. DEP'T. LAB. INSP. GEN. SEMIANN. REP. OCT. 1, 1996 - MAR. 31, 1997, at 46.

Two "bogus union" officials pled guilty in 1996 to Federal racketeering charges for forming a union solely for the purpose of selling fraudulent insurance. DEP'T. LAB. INSP. GEN. SEMIANN. REP. APR. 1, - SEPT. 30, 1996, at 42. Thomas Cucuro and Joseph Bartolomeo pled guilty to soliciting and receiving $300,000 in kickbacks from insurance brokers who sold insurance to employee benefit plans affiliated with Cucuro's and Bartolomeo's union. The case came to the attention of law enforcement officials after the employee benefit fund was placed under the control of a court-

appointed trustee as a result of the fund's outstanding $6 million of unpaid medical claims. *Id.* The Inspector General of the United States Department of Labor concluded that "[t]his case exposed a weakness in the Government's regulatory scheme by permitting what is, in essence, an insurance operation to assume the cloak of ERISA preemption, those avoiding more stringent regulation by State Insurance Commissioners." *Id.* at 43. In light of the difficulties State insurance regulators face in preventing and prosecuting MEWA fraud, it is apparent that additional enforcement mechanisms are drastically needed. RICO's civil enforcement mechanism provides the most potent remedies and effective deterrent for this type of fraud.

B. No Other Remedies Are As Effective As RICO in Combating White Collar Crime and Pattern Corporate Fraud.

1. This Court's Liberal Construction of RICO Allows Private Plaintiffs to Use its Treble Damages Remedy to Fight Fraud in Significant Cases Involving Patterns of Fraud, Even Outside of Organized Crime.

RICO's broad applicability to patterns of fraud outside the realm of organized crime is due to the statute's liberal construction. Congress specified that RICO should "be liberally construed to effectuate its remedial purposes." 84 Stat. 947 (1970). This Court has repeatedly recognized and applied this provision, and has repeatedly reaffirmed that the statute is to be broadly and liberally construed. *See Holmes v. Securities Investor Protection Corp.*, 503 U.S. 258, 274 (1992); *H.J., Inc. v. Northwestern Bell Telephone* Co., 492 U.S. 229, 249 (1988); *Sedima, S.P.R.L. v. Imrex* Co., 473 U.S. 479, 497-98 (1985); *United States v. Turkette*, 452 U.S. 576, 587, 593 (1981). As this Court has also recognized, "Congress knew what it was doing when it adopted commodious language capable of extending beyond organized crime." *H.J., Inc. v. Northwestern Bell Tel. Co.*, 492 U.S. at 246.

RICO is thus a crucial part of the arsenal available to those combating white collar crime and patterns of fraud.[9] RICO serves to combat such patterns of fraud in two ways: it is "both preventative and remedial." *Turkette*, 452 U.S. at 593. A number of courts have noted that RICO is a powerful and effective addition to the legal weapons that may be brought to bear against fraudulent enterprises. In *Genty v. Resolution Trust Corp.*, 937 F.2d 899, 910 (3d Cir. 1991), the court observed:

> Congress supplemented the criminal penalties of RICO with this extraordinary [treble damage] civil provision in furtherance of its concern in protecting the public from the evils of racketeer-influenced enterprises. The criminal and civil penalties in the Act thus comprise sharply-cutting edges of a double-edged sword to strike more completely the insidious influences plaguing our nation's enterprises. . . . And as we have previously declared, Congress enlarged "the number of tools with which to attack the invasion of the economic life of the country by the cancerous influence of racketeering activity." *United States v. Frumento*, 563 F.2d 1083, 1090 (3d Cir. 1977).

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[9] It seems likely that RICO has not been as effective a deterrent to fraud by insurance companies as it has been to fraud by other entities because of the possibility that courts might find that RICO claims against insurers are barred by the McCarran-Ferguson Act. Two courts of appeals have barred RICO suits against insurance companies. *Doe v. Norwest Bank Minnesota*, 107 F.3d 1297, 1306-08 (8th Cir. 1997) (RICO actions barred by McCarran-Ferguson); *Kenty v. Bank One, Columbus, N.A.*, 92 F.3d 384, 392-93 (6th Cir. 1996) (same). Others, however, have permitted juries to hear those claims. These cases demonstrate the type of frauds RICO is necessary to redress. *See also Schroder v. Acceleration Life Ins. Co.*, 972 F.2d 41 (3d Cir. 1992) (reversing grant of summary judgment in favor of insurer on the plaintiffs' RICO claim, which alleged that the insurer promised to pay benefits it never intended to pay and that it knowingly calculated benefits improperly); *Ocean Energy, II v. Alexander & Alexander*, 868 F.2d 740 (5th Cir. 1989) (reversing grant of summary judgment in favor of insurer on the plaintiffs' RICO claims, which alleged that the insurer made false representations about its insurance program in mailings and that its insurance programs violated state law).

The key to RICO's unique effectiveness is its treble damages remedy, which has the powerful effect of encouraging private parties to enforce the act's prohibitions against white collar crime and systemic fraud. As this Court has said with respect to an analogous provision in the Clayton Act, "Congress created the treble-damages remedy . . . precisely for the purpose of encouraging private challenges to . . . violations." *Reiter v. Sonotone Corp.*, 442 U.S. 330, 344 (1979). *See also Shearson/American Express, Inc. v. McMahon*, 482 U.S. 220, 241 (1987) (treble damages provision creates "vigorous incentives for plaintiffs to pursue RICO claims"). The treble damages remedy also serves to deter white collar crime, and to ensure that the victims of white collar crimes will be adequately compensated for all of their losses, where single damage remedies only compensate victims for the more narrow category of losses recognized by traditional legal remedies. *See Blue Shield v. McCready*, 457 U.S. 465, 472 (1982) (treble damages remedies of the antitrust laws create a "private enforcement mechanism that . . . deter[s] violators . . . and provide[s] ample compensation to the victims. . . .").

Courts and commentators have recognized that traditional legal damages often do not fully compensate victims. "[T]reble damages . . . go beyond the scope of compensatory damages and make the victim whole for any accumulative harm. . . . Accumulative harm is that harm falling outside the range of legal damages, too elusive and indeterminate for adequate measurement by traditional damage principles. . . ." Judith Morse, *Treble Damages Under RICO: Characterization and Computation*, 61 Notre Dame L. Rev. 526, 528 and 528 n.13 (1986) (citations omitted). RICO's treble damages help ensure that a plaintiff injured by a violation of RICO will receive what they deserve: a "complete recovery." *Carter v. Berger*, 777 F.2d 1173, 1176 (7th Cir. 1985).

2. No Alternative Adequate Remedies Exist to Combat Fraud by Employee Benefit Plans Because ERISA Preempts a Wide Variety of State Causes of Action.

RICO's powerful and effective remedies are particularly crucial with respect to health insurance plans covered by ERISA, because ERISA's expansive preemption provisions have been interpreted as preempting a wide range of State statutory and common law remedies for the victims of patterns of fraud against health insurance plans.

ERISA's Preemption Clause, 29 U.S.C. § 1144(a), provides that ERISA supersedes any and all State laws that relate to, refer to or have a connection with any employee benefit plan. The only exception to this broad preemption clause is ERISA's Savings Clause, 29 U.S.C. § 1144(b)(2)(A), which preserves from Federal preemption State laws regulating the business of insurance. In determining whether a State cause of action regulates the business of insurance, this Court has held that courts should use three criteria used for the McCarran-Ferguson Act: (1) whether the practice has the effect of transferring or spreading a policyholder's risk; (2) whether the practice is an integral part of the policy relationship between the insurer and the insured; and (3) whether the practice is limited to entities within the insurance industry. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740-43 (1985). This Court has also added that, to be exempt from ERISA's preemptive scope under ERISA's Savings Clause, a State law must be specifically directed toward the insurance industry. *Pilot Life Ins. v. Dedeaux*, 481 U.S. 41, 48-50 (1987).

Courts employing these criteria have regularly found that nearly every State law cause of action that might be employed against a systemic fraud by an insurance company is not a regulation of the business of insurance, and thus *is* preempted by ERISA. Accordingly, the district court in this case dismissed Respondents' State RICO claims as preempted by ERISA. 827 F. Supp. at 1509. A number of other courts have found that causes of action

arising from State deceptive trade practice acts are preempted by ERISA, generally on the grounds that those causes of action are not aimed exclusively at the insurance industry. *See, e.g., Custer v. Pan American Life Ins. Co.*, 12 F.3d 410 (4th Cir. 1993) (claims against insurer under West Virginia Unfair Trade Practice statute are preempted by ERISA); *Kanne v. Connecticut Gen. Life Ins. Co.*, 867 F.2d 489 (9th Cir.) (ERISA preempts private right of action created by California Insurance Code for unfair insurance practices), *cert. denied*, 492 U.S. 906 (1988); *Ryan v. Fallon Community Health Plan, Inc.*, 921 F. Supp. 34 (D. Mass. 1996) (ERISA preempts claims under Massachusetts statute prohibiting unfair and deceptive insurance practices); *McManus v. Travelers Health Network of Texas*, 742 F. Supp. 377 (W.D. Tex. 1990) (ERISA preempts the Texas Deceptive Trade Practices Act, as it "is not 'specifically directed' toward the insurance industry"); *Worthington v. Metropolitan Life Ins. Co.*, 688 F. Supp. 298 (S.D. Tex. 1987) (ERISA preempts claims under Texas Insurance Code and Texas Deceptive Trade Practices Act). Courts have also frequently held that ERISA preempts causes of action for State common law fraud. *See, e.g., Lister v. Stark*, 890 F.2d 941 (7th Cir. 1989), *cert. denied*, 498 U.S. 1011 (1990); *Amos v. Blue Cross-Blue Shield*, 868 F.2d 430 (11th Cir.), *cert. denied*, 493 U.S. 855 (1989); *Sandler v. Marconi Circuit Technology Corp.*, 814 F. Supp. 263 (E.D.N.Y. 1993); *Barr v. American Cyanamid Co.*, 808 F. Supp. 752 (W.D. Wash. 1992).

Moreover, under ERISA, an award of attorney's fees is discretionary. *See* 29 U.S.C. § 1132(g) ("the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.") Advocates for elderly and employees' rights have noted that the inconsistent and unpredictable results caused by this provision, and the possibility that even a prevailing litigant will be denied a fee award, have resulted in attorneys' unwillingness to risk undertaking litigation. *See* AMERICAN ASS'N OF RETIRED PERSONS, STATEMENT BEFORE THE WORK GROUP ON ENFORCEMENT OF THE ADVISORY COUNCIL ON EMPLOYEE WELFARE AND PENSION BENEFIT PLANS OF THE U.S. DEP'T OF LABOR, Aug. 20, 1990, at 4; *Proposals to Strengthen ERISA*

Enforcement: Hearing Before the Subcomm. on Labor of the Senate Comm. on Labor and Human Resources, 101st Cong., 2d Sess., 8 (1990) (statement of Jeffrey Lewis of the National Employment Lawyers Association). RICO, by contrast, more definitively provides for recovery of attorney's fees. *See* n.3, *supra*.

In this case, if this Court were to reverse the Court of Appeals' decision, Humana would be liable only under ERISA. *See* 114 F.3d at 1475 (affirming district court's judgment for damages under 29 U.S.C. § 1132(a)(1) for the amounts they were forced to pay above their co-payment). The district court dismissed the Respondents' State law claims, including their State RICO claim, as preempted by ERISA. *Forsyth v. Humana, Inc.*, 827 F. Supp. at 1509.[10] ERISA remedies provide only that Humana return the wrongfully obtained portion of the co-payment. Under ERISA, then, Humana would only be required to refund to the policyholder the amount Humana would have owed the policyholder had it not committed fraud. Without the threat of RICO's more powerful remedies, an insurance company engaging in such a scheme risks only having to pay back to the consumer what it was originally owed. RICO's remedies – including treble damages and attorney's fees – create more powerful incentives for enforcement and serve as a more effective deterrent in preventing future cases of such fraud.

CONCLUSION

For these reasons, the decision below should be affirmed.

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[10]The Court of Appeals did not review this ruling and it is not before this Court. *Forsyth v. Humana*, 114 F.3d at 1474.

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